IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

STEPHON LINDSAY, #207044,	)	
	)	
PLAINTIFF,	)	
	)	
V.	)	**CIVIL ACTION NO.: 2:07-CV-399-MHT [WC]**
	)	
RICHARD ALLEN, WARDEN CUMMINS, SANDRA GILES, SYLVESTER NETTLES, RUTHIE PERRY, J. HUDSON, L. HERBERT, CORRECTIONAL OFFICER SCREECHER, CORRECTIONAL OFFICER HAMPTON, CORRECTIONAL OFFICER TALLEY, CORRECTIONAL OFFICER BENNETT, A. JACKSON, CORRECTIONAL OFFICER BASKIN, CORRECTIONAL OFFICER MARTIN, CORRECTIONAL OFFICER HILL, CORRECTIONAL OFFICER CURRY, CORRECTIONAL OFFICER BEECHAM, CORRECTIONAL OFFICER BAILEY, CORRECTIONAL OFFICER HANES, PRISON HEALTH SERVICES, INC., DR. TAHIR SIDDIQ, NURSE ETHEN, AND NURSE JACQUELINE DUBOSE,	)	
	)	
DEFENDANTS.	)	

DEFENDANTS' NOTICE OF FILING

COME NOW, Defendants DR. TAHIR SIDDIQ ("Dr. Siddiq"), JACQUELINE DUBOSE ("Nurse Dubose") and PRISON HEALTH SERVICES, INC. ("PHS," collectively with Dr. Siddiq and Nurse Dubose, the "Medical Defendants"), by and through their respective counsel of record and in response to the request of this Court pursuant to the Order dated September 12, 2007, to file with the court and provide to the Plaintiff STEPHON LINDSAY ("Plaintiff") legible copies of the documents identified by the Plaintiff in his letter to counsel

dated August 2, 2007, and submit the materials attached hereto. After consultation with appropriate individuals, undersigned counsel states that the attached documents represent the most legible copies of the identified medical records which are available at this time and, if the Court so chooses, Medical Defendants will make the original medical records available to Plaintiff at his current place of incarceration.

Respectfully submitted,

s/ William R. Lunsford
One of the Attorneys for Prison Health Services, Inc., Dr. Tahir Siddiq and Jacqueline Dubose

OF COUNSEL:
William R. Lunsford
MAYNARD, COOPER & GALE, P.C.
655 Gallatin Street
Huntsville, Alabama 35801
Telephone: (256) 551-0171
Facsimile: (256) 512-0119
Email: blunsford@maynardcooper.com

CERTIFICATE OF SERVICE

I hereby certify that on the 28th day of September, 2007, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system and mailed via regular U.S. mail to the following:

Stephon Lindsay
AIS 207044
Ventress Correctional Facility
P.O. Box 767
Clayton, Alabama 36016-0767

s/ William R. Lunsford
Of Counsel

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Form must be Complete and Legible. You must Type or Print
Please send this form with the Authorization Letter to the service provider at the time of the Appointment

RECEIVED JAN 22 2007

DEMOGRAPHICS

Site Name & Number:	Patient Name: (Last, First)	Date: (mm/dd/yy)
BULLOCK 832	Lindsay Stephon	01/23/07
Site Phone #	**Alias: (Last, First)**	**Date of Birth: (mm/dd/yy)**
(334)738-5625		09/06/77
Site Fax #	**Inmate #**	**PHS Custody Date: (mm/dd/yy)**
(334)738-8763	207044	/ /
Will there be a charge? ☑ Yes ☐ No	**Sex** ☑ Male ☐ Female	**SS Number**	**Potential Release Date: (mm/dd/yy)** 00/00/00

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☑ NP, PA ☐ Dental

Facility Medical Director Signature and Date: DSV

☐ Service meets criteria for "approval via protocol"

History of illness/injury/symptoms with Date of Onset:
Pt after surgery to fractured Forearm

Results of a complaint directed physical examination:
DSV

Previous treatment and response (including medications):
None

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) / /

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy
Number of Visits/Treatments: ____ ☐ other: ____

Specialist referred to: Dr. Chung 8/3 8/7

Type of Consultation, Treatment, Procedure or Surgery:
Dr Chung 8/3
Fractured Forearm (ORIF)

Diagnosis: Fractured Forearm
ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☑ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information. Date resubmitted: / /

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Regional Medical Director Signature, printed name and date required: 1/22/07 (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: OKU	Med Class: OV	CPT code: 99024	UR Auth #: 16878343

05a – UM Referral review form

FAX [redacted] 2007

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Patient Name:	Lindsay, Stephon	**Inmate Number:**	207044LI
Service Authorized:	Office Visits: Op Surgical Followup Referral	**Effective Dates:**	01/22/2007
Effective:	Visits authorized for 60 days from effective date.	**Visits Authorized:**	1
Responsible Facility:	Bullock Correctional Facility	**Contact Name:**	Michelle Pope
Authorization Number:	16878343	**Telephone Number:**	(334)395-5973 Ext 14

Note to Provider of Services:

- **Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.**
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
Attn: Claims Department
105West Park Drive, #200
Brentwood, TN 37024-0967

The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

Clinical Summary or Attached Report

[illegible handwritten clinical notes]
Wnd clean
[illegible] ok → good
Replace splint
[illegible]

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***** For security and safety, please do not inform patient of possible follow-up appointments. *****

Signature of Consulting Physician: [signature] Date Time

Reviewed and Signed By Medical Director: 2/6/[illegible] Date Time

Dr. Chung
6936 Winton Blount
Montgomery, AL
260-2288
February 5 at 10 AM

01/22/2007

PHS000059

E0701800445 LINDSAY,STEPHON
DOB: 09/06/77 Age:29Y MR #:297831
Admit Date/Time: 01/19/07 0916A
2015 CHUNG,TAI Q

Baptist HEALTH

PHYSICIAN'S ORDERS

Height:_____ Weight:_____

Drug Sensitivities and Allergies ☐ NKDA ☐ Yes, list: _____

New Admissions Only:

1. Diagnosis:

2. Admit Status: ☐ Inpatient Admission ☐ Outpatient Status ☐ Observation Status

Date	Time	
		Dr
1/19/07		Please make a Xerox copy of my orders for his attendants to return to his facility
		① Elevate L arm
		② Change dressing prn
		Keep splint on
		③ Vicodin 1-2 po q 4-6 h prn pain
		Cephalexin 500 mg po qid x 7d
		④ Bo Bmm bunk bed
		⑤ See me in 1 wk
		Stanley Chung
		Abraham 1/19/07 1045
		1/21/07

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Physician Signature:

The following abbreviations are not to be written or used!

Q.O.D., QOD, q.o.d, qod	Trailing zero (X.0 mg)	Lack of leading zero (.X mg)	MS	MSO4	MgSO4	U	q.d., QD, qd	IU

PH 350

Form #PH 35001 Revised 11/18/05

TAI Q. CHUNG M.D.

DATE 1/12/07

NAME Stephen Lindsay

PHONE ____ HOME _____ WORK _____

PROCEDURE ORIF & w/re.

DX fx Calc CPT _____

WHERE _____ OUTPATIENT _____

TIME NEEDED 4hrs

ANETHESIA GENERAL ____ BLOCK ____ LOCAL ____ CHOICE _____

SPEICAL EQUIPMENT small fragment set
C-arm

ASSISTANT _____

LABS _____

BLOOD TRANSFUSIONS _____

OTHER INSTRUCTIONS _____

SURGERY OR TEST DATE _____

INSURANCE INFORMATION _____

Stryder Lindsay
Patient Information

Baptist HEALTH

PHYSICIAN'S ORDERS

Height:_____ Weight:_____

Drug Sensitivities and Allergies ❑ NKDA ❑ Yes, list: _____

Date	Time	ROUTINE PRE OPERATIVE ORDERS DR. JM CANN
		1. Operative permit for: Open reduction and internal fixation (L) ulna
11/21/08		2. LAB: check appropriate diagnosis
		A. _____ CBC:
		_____ Pre op patient [V72 83] _____ Abdominal pain
		_____ Long term use of medications _____ Other
		_____ Fever
		B. _____ TYPE & SCREEN
		C. _____ CHEM 7:
		_____ Edema _____ Nephropathology
		_____ Hypertensive disease _____ Dizziness
		_____ Long term use of medications _____ Other
		_____ Diabetic
		D. _____ PT PTT
		_____ Known or suspected _____ Cirrhosis hepatitis
		coagulation abnormality _____ CHF
		_____ Anticoagulatn therapy _____ Cardiac dysrhythmia
		_____ Hemorrhage or anemia _____ Dysfunctional uterine bleeding
		_____ Pulmonary congestion _____ Menorrhagia
		_____ Other
		E. _____ DRUG LEVELS: circle appropriate drug
		_____ Patients taking Digoxin Tegretol Theophylline Dilantin Depakote
		Phenobarb
		_____ Other
		F. _____ URINE PREGNANCY
		_____ On all menstruating females
		Physician Signature: [signature]

The following abbreviations are not to be written or used!

Q.O.D., QOD, q.o.d, qod	Trailing zero (X.0 mg)	Lack of leading zero (.X mg)	MS	MSO4	MgSO4	U	q.d., QD, qd	IU

PH 350

Form #PH 35020 Revised 11/18/05

Patient Information

Baptist HEALTH

PHYSICIAN'S ORDERS

Height: _____ Weight: _____

Drug Sensitivities and Allergies ❑ NKDA ❑ Yes, list: _____

Date	Time	ROUTINE PRE OPERATIVE ORDERS DR. _____
		G. _____ UA:
		_____ Diabetic _____ Fever
		_____ Renal glycosuria _____ Dysuria
		_____ Dehydration _____ Abdominal & pelvic pain
		_____ Stress incontinence _____ Long term use medication
		H. ADDITIONAL LAB TESTS:
		3. **EKG:**
		_____ MVP/murmer or other _____ Tachycardia/palpitation
		valve disorder _____ Ischemic heart disease (hx MI)
		_____ Chest pain discomfort _____ Dizziness
		pressure _____ Other
		_____ Hypertensive disease
		_____ Pulmonary congestion & hypostasis (CHF)
		_____ Electrolyte/fluid abnormality
		4. **CHEST XRAY:**
		_____ Existing pulmonary disease (asthma COPD etc)
		Specify:
		_____ Existing cardiac disease (hypertension CHF etc)
		_____ Internal Injury
		_____ Fever
		_____ Cough
		_____ Disorders of bone & cartilage (arthritis)
		_____ Other
		5. _____ **Antibiotic:**
		6. _____ **NPO after midnight**
		7. _____ **❑ TED or ❑ SCD hose prior to surgery**
		8. _____ **Other Orders:**
		9. **Anesthesia Consult ❑ Yes ❑ No**
		Physician Signature:
		Page 2 of 2

The following abbreviations are not to be written or used!

Q.O.D., QOD, q.o.d, qod	Trailing zero (X.0 mg)	Lack of leading zero (.X mg)	MS	MSO4	MgSO4	U	q.d., QD, qd	IU

PH 350

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be complete and legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: BULLOCK 832

Patient Name: (Last, First) Lindsay Stephon

Date: (mm/dd/yy) 01/16/07

Site Phone # (334)738-5625

Alias: (Last, First)

Date of Birth: (mm/dd/yy) 09/06/77

Site Fax # (334)738-8763

Inmate # 207044

PHS Custody Date: (mm/dd/yy) ___/___/___

Will there be a charge? ☑ Yes ☐ No

Sex ☑ Male ☐ Female

SS Number ___-___-____

Potential Release Date: (mm/dd/yy) 00/00/00

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):___

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Facility Medical Director Signature and Date:

☐ Service meets criteria for "approval via protocol"

History of Illness/injury/symptoms with Date of Onset:

Inmate c fractured Ulnar shaft

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: _____ ☐ Other:_____

Results of a complaint directed physical examination:

Specialist referred to: Dr. Chung

Type of Consultation, Treatment, Procedure or Surgery:

Dr Chung

Diagnosis: Fractured Ulna

ICD-9 code:

Previous treatment and response (including medications):

Advil

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

Date resubmitted: ___/___/___

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Regional Medical Director Signature, printed name and date required:

___/___/___ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	CPT code:	UR Auth #:

05a - UM Referral review form

PHS PRISON HEALTH SERVICES INCORPORATED

EMERGENCY

ADMISSION DATE	TIME	ORIGINATING FACILITY	
01 /08/07	4 10 AM PM	BCCF ☐ SIR ☐ PDL ☐ ESCAPEE ☐	☐ SICK CALL ☐ EMERGENCY ☒ OUTPATIENT

ALLERGIES NKA

CONDITION ON ADMISSION ☐ GOOD ☒ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

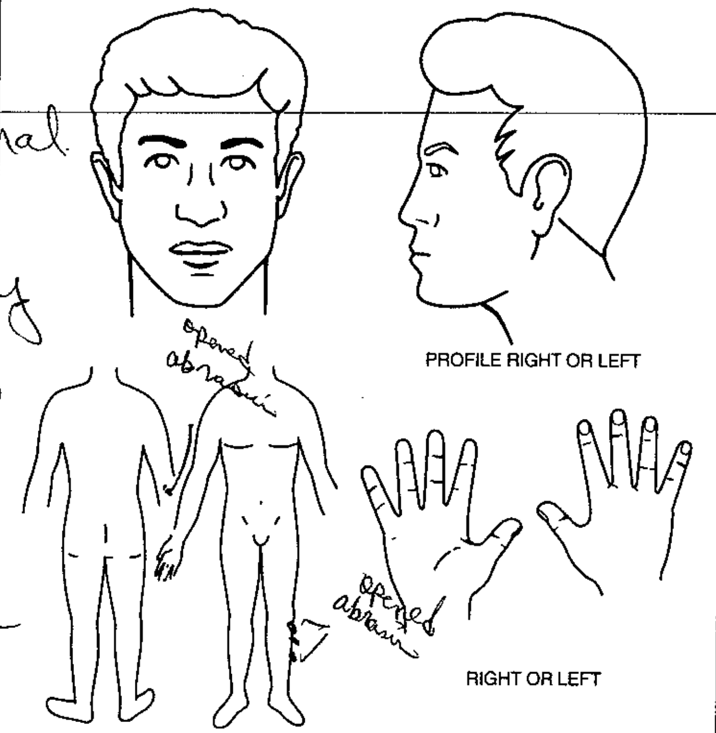
VITAL SIGNS: TEMP ——— ORAL RECTAL RESP. 22 PULSE 76 B/P 130/88 RECHECK IF SYSTOLIC <100> 50 N/A

NATURE OF INJURY OR ILLNESS

S- Body Chart for DOC

O- Blk male, excorted to HCU c̄ hand Cuffed behind his back - accomp by several Officers - I/M male alert + Oriented X3. Resp reg + even Color adeq - Skin warm + dry c̄ small abrasion noted back (R) elbow and (L) lower leg on Shin bone Substained (3) Medium Size opened area

ABRASION /// | CONTUSION # | BURN xx | FRACTURE Z | LACERATION / ___ SUTURES



PHYSICAL EXAMINATION

I/M was checked + examined by Dr Siddiq - eyes redden due to uses of Pepper Spray. No Alteration in Comfort to bodies injuries.

P- Eyes rinsed c̄ Sterilize Solution.-
- Area Cleanse H2O2 + NS followed by TAO + drsg.
- Advil 800mg PO Tid X10 days
- X-Ray of (R) lower arm + (L) lower leg.

ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY

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DIAGNOSIS

INSTRUCTIONS TO PATIENT
Return PRN

DISCHARGE DATE	TIME	RELEASE / TRANSFERRED TO	CONDITION ON DISCHARGE
01/8/07	4:35 AM PM	☒ DOC ☐ AMBULANCE ☐	☐ SATISFACTORY ☒ FAIR ☐ POOR ☐ CRITICAL

NURSE'S SIGNATURE	DATE	PHYSICIAN'S SIGNATURE	DATE	CONSULTATION
Robbin	1/8/07	[signature]		

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
Lindsay Stephon	207044	9/6/77	B/M	BCCF

PHS000087

PRISON HEALTH SERVICES INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name: Lindsay, Stephon 207044 D.O.B.: 9/6/77
1/28/06 TSP PA	Rec'd @ Bullock c Vol I g I. Had f/u meds and f/u mar. — J Howard MSC
1/20/07	Pt returned from Baptist H. Medical Center. Surgery to (R) arm. Dsg: dry & intact. Pt alert & oriented x 3. C/o some discomfort. Medication for pain given as ordered. Recommended f/u in 2 wks c Dr. Chung. Will confer c M D, DaSiddiq. — S. Roberts RN

PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: D.O.B. / / ALLERGIES: Use Last Date / /	DIAGNOSIS (If Chg'd) FOR PROFESSIONAL USE ONLY CONFIDENTIAL RECORD NOT TO BE RECOPIED ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: D.O.B. / / ALLERGIES: Use Fourth Date / /	DIAGNOSIS (If Chg'd) ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: D.O.B. / / ALLERGIES: Use Third Date / /	DIAGNOSIS (If Chg'd) ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Lindsey, Stephon #267044 D.O.B. / / ALLERGIES: 3/9/07 Noted 3-9-07 [illegible] Use Second Date / /	DIAGNOSIS (If Chg'd) Amoxil 500 [illegible] [illegible] ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Lindsey Stephon 267044 D.O.B. / / ALLERGIES: 1/21/07 1/21/07 [illegible] Noted [illegible] Use First Date / 120107	DIAGNOSIS 1) Elevate ARm 2) Percogesic ii po x 2days tid 3) Cephalexin 500mg tid x 2days 4) Bottom Bunk Bed 5) Change dressing PRN per T.O. DrSiddiqi / Siebert SRN ☒ GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY